

BOOK REVIEWS

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THE HOSPICE STORY IN CALIFORNIA—Third Edition—California Medical Association, Committee on Evolving Trends in Society Affecting Life. Sutter Publications, Inc., 731 Market Street, San Francisco, CA (94103), 1979. 215 pages, \$10.00.

The July 1978 issue of THE WESTERN JOURNAL OF MEDICINE contained an article providing information on the status of the hospice movement in the state of California as of the early part of that year ("Hospices for Terminally Ill Patients"). The article dealt with the hospice concept, the recommendations of the California Medical Association's (CMA) Committee on Evolving Trends in Society Affecting Life, and the action of the CMA in support of that concept. The main body of the article discussed the results of a survey conducted in February 1978 to determine the characteristics of California hospices, as well as some preliminary information on costs. The overview mentioned some then-existing problems and raised a question about one of the observed weaknesses of the movement in that it did not always show evidence of having a broad cross-section of community support. The following months witnessed a tremendous surge of activity in communities throughout California to initiate planning and organizational efforts to respond to the interest shown by the public and health professionals in hospice development. The Committee on Evolving Trends in Society Affecting Life authorized the collection of more current data and the publication of another edition of *The Hospice Story in California*, a compilation which had gone through two editions and which contained descriptions of the history, structure, organization, and operation of 12 and 13 hospices, respectively, which had submitted reports based on an outline previously provided to them.

From the 16 hospices known to be operational in the early part of 1978, the number had grown to approximately 40 in the spring of 1979; at least a dozen others were on the verge of starting their programs. Questions addressed to the Committee by other physicians, state and county medical associations, community groups, and health and social work professionals prompted the request to the hospices to update their material as well as to provide demographic data about their patients and to include examples of evaluation efforts which could be utilized by other hospices.

The third edition of *The Hospice Story in California* contains information submitted by the hospices describing the beginning efforts at data collection and provides information about the characteristics of terminally ill patients, duration of hospice services, costs of providing such services, budgets, sources of funding and some of the problems encountered. Included are many references to future plans, indicating what problems have yet to be overcome.

The publication contains descriptions of 41 hospices, three of which are not yet operational but whose experiences were considered worth sharing with other groups in their developmental stages.

Analysis of the data pertaining to the programs in operation as of July 1 shows that more than half of them (21) started during 1978-79; almost as many were begun in 1978 as had started during the previous four years.

The 38 hospices are located in 22 of the 58 counties

in California, with some drawing patients from more than the county in which they are situated. As might be expected, Los Angeles County has the greatest number, while Ventura, San Diego, Santa Barbara, Sonoma, and Contra Costa each have more than one.

Among the sources of hospice sponsorship, broad-based community support ranks first; half of the hospices fall in this category, followed closely by hospital sponsorship. In the latter, the hospital board of directors generally serves as the hospice board, although a question may be raised as to the nature and extent of their interest and involvement inasmuch as their first allegiance is to the hospital itself.

Oriented as hospices are to home care services, it is not surprising to find that the majority of the hospices have the homes of terminally ill patients as the primary sites of service. Hospices also provide their services to patients when they are confined to a hospital, nursing or convalescent facility at some time during the course of illness. In those hospices that are hospital-based, home care services are provided to supplement in-patient services.

The necessity of having a medical director either part or full time, or on a consulting basis, is readily recognized by virtually all of the hospices. The medical director serves as an important link in the continuing relationship with the patient's physician and provides the professional direction/supervision that is a necessary part of the interdisciplinary team in which nurses, other health professionals, clergy and volunteers play an important role.

Medical or professional advisory committees (or both) are evident in more than half of the hospice programs.

The importance of adequate training of all personnel, whether paid or volunteer, is acknowledged by all hospices, as is the emphasis on the importance of identifying the hospice concept with an interdisciplinary effort, without which no hospice can succeed.

The importance of broadening the base of community support and representation is being recognized, as is the need for more uniform data collection and evaluation. It would appear that at present most of the evaluation measures take the form of internal discussions among staff regarding patient response to care and physician acceptance of the program. A handful of hospices have gone beyond this stage of evaluation and are employing more sophisticated measures and techniques. It is expected that evaluation efforts of all the hospices will expand in this direction as they gain more experience and become more firmly established.

The latest edition of *The Hospice Story in California* calls attention to one serious deficiency. Descriptions of hospice activity and services rarely mention that terminally ill patients will be served *regardless of their ability to pay*. This omission appears to negate a basic element and principle of the philosophy of hospice care, one which has survived over the centuries and is again emerging as a potent force—that of demonstrating the qualities of humanity and compassion which bind all people.

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